United States Court of Appeals

for the Second Circuit

BRIEF FOR APPELLEE

76-6144

In The

United States Court of Appeals

For the Second Circuit

B P/S

CERVIA M. WEIMER,

Plaintiff-Appellant,

vs.

ELLIOT RICHARDSON, Secretary of Health, Education and Welfare,

Defendant-Appellee.

In Forma Pauperis

Appeal from the United States District Court for the Western District of New York

BRIEF FOR APPELLEE

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BRIEF FOR APPELLEE

APPLICABLE STATUTES

Section 223 of the Act, 42 U.S.C.A. 423, provides that:

"(a)(1) Every individual who —

"(A) is insured for disability insurance benefits (as determined under subsection (c)(1)),

"(B) has not attained the age of sixty-five,

"(C) has filed application for disability insurance benefits, and

"(D) is under a disability (as defined in subsection (d)) shall be entitled to a disability insurance benefit . . . ending with the month preceding . . . the third month following the month in which his disability ceases."

* * *

"(d)(1) The term 'disability' means

"(A) inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months;"

"(2) For purposes of paragraph (1)(a) —

"(A) an individual . . . shall be determined to be under a disability only if his physical or mental impairment or impairments are of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work. For purposes of the preceding sentence (with respect to any individual), 'work which exists in the national economy' means work which exists in significant numbers either in the region where such individual lives or in several regions of the country.

"(3) For purposes of this subsection, a 'physical or mental impairment' is an impairment that results from anatomical, physiological, or psychological abnormalties which are demonstrable by medically acceptable clinical and laboratory techniques.

* * *

"(5) An individual shall not be considered to be under a disability unless he furnishes such medical or other evidence of the existence thereof as the Secretary may require."

The requirements of section 216(i) relating to the establishment and continuation of a period of disability are substantially the same as the above-quoted provisions of section 223.

NATURE OF THE ACTION

This is an action brought under the Social Security Act, as amended, 42 U.S.C. §405(g), to review a final determination of the Secretary of Health, Education and Welfare, which denied plaintiff-appellant's application for a period of disability and disability insurance benefits.

PRIOR PROCEEDINGS

Plaintiff filed application for a period of disability and for disability insurance benefits on December 2, 1968 (Tr. 50-53),* alleging that she became unable to work in June 1967, at age 52. The application was denied initially (Tr. 56-57) and on reconsideration (Tr. 61-62). The hearing examiner, before whom plaintiff appeared, considered the case *de novo*, and on December 10, 1969, found that the plaintiff was not under a disability (Tr. 6-13). Following denial of her request for review of the hearing examiner's decision by the Appeals Council (Tr. 3), plaintiff brought an action in District Court for Western District of New York requesting judicial review. On its own motion, the District Court remanded the case to the Secretary of the Department of Health, Education and Welfare (Secretary) for the taking of additional evidence.

Upon receipt of additional evidence, and after consideration of the entire record, the Appeals Council rendered a decision on January 29, 1973, holding that plaintiff was not disabled on or before September 30, 1971, when she last met the special earnings requirement of the Social Security Act (Tr. 123-127).

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*References in this brief to "Tr." refer to the transcript of the Administrative Hearings and "App." to the Appendix herein.

The decision of the Appeals Council is the final decision of the Secretary.

On March 18, 1976 the government moved for summary judgment and the District Court granted that motion on June 29, 1976 (App. p.). It is this order that is sought to be reviewed in this appeal.

ISSUE

The only issue to be determined by the court is whether the Secretary's decision that appellant was not under a disability, at any time when she met the insured status requirements of the Act, is supported by substantial evidence.

STATEMENT OF FACTS

Plaintiff, a fifty-seven year old female with an eleventh grade education, has alleged disability since June 1967, at age fifty-one, due to osteoarthritis plus complications (Tr. 25, 50).

The medical evidence of record prior to remand is as follows:

Dr. Joseph Karp, general practitioner (Tr. 113), reported first examining plaintiff on Febrary 2, 1965 and last examining her on April 6, 1965 (Tr. 90). A chest X-ray indicated a tendency toward pulmonary emphysema with an occasional fibrous strand at each base (Tr. 93). Urinalysis revealed negative findings and CBC was normal except for hemoglobin which was 12.5 GM. At the time of her last office visit she was suffering from rose and hayfever (Tr. 90). Plaintiff had been prescribed iron and advised to try to work.

Plaintiff was next seen by Dr. Robert C. McVeigh, general practitioner (Tr. 114), who examined her on August 30, 1965

(Tr. 94). She complained of pain in the right shoulder with radiation to the head and neck. Physical examination was within normal limits except for a blood pressure of 170/90-100 and tenderness over the right sub deltoid area (Tr. 95). A chest X-ray of February 6, 1965 had indicated a tendency to pulmonary fibrosis and emphysema. An undated cervical spine X-ray indicated minimal degenerative changes. Plaintiff was started on Butazolidin and Valium and the Valium was later changed to Indocin (Tr. 96). Dr. McVeigh stated that he did not doubt that she was physically capable of doing some type of work, but emotionally she might be unable to adopt to any new position (Tr. 96-97). Diagnoses were anxiety state, right sub deltoid tendonitis, mild essential hypertension and pulmonary emphysema by X-ray (Tr. 95).

It was reported by Dr. Alinaghi Farrokh, internal medicine; cardiovascular diseases (Tr. 115), that he saw plaintiff on three visits to her house beginning January 9, 1969 (Tr. 98). The visits were mainly for symptoms and signs of ordinary flu and common cold. She had a moderate degree of degenerative arthritis of various joints but no evidence was found of articular or neuromuscular dysfunction. She appeared to have a great deal of psychosomatic problems. The physician reported that he had been unable to persuade plaintiff to come to his office for a physical examination to obtain laboratory data. Diagnoses were degenerative osteoarthritis, few episodes of common cold and flu, plus anxiety and neurosis.

Dr. Benjamin Pollack, neuropsychiatrist (Tr. 116), evaluated plaintiff on March 10, 1969 (App. 35, Tr. 102). She walked into the office fairly freely and displayed no difficulty in walking but later on, in the interview, she gave many complaints (Tr. 102). She was a fairly well nourished, well dressed woman who showed no signs of disability. She frequently laughed and joked and seemed to be at ease as she initiated much conversation. She was spontaneous, coherent, relevant and well oriented for time

and place. She complained of inability to sleep due to joint pain and headache and also pointed out that she had pain in her fingers which were a little better as of the examination (Tr. 102). She stated that she could not hold an iron with her right hand, where the pain was much worse (Tr. 102-103). It was noted that there was no swelling in her right hand, no sign of interference with function or sign of arthritis, deformity, swelling or joint pain. She also stated her heart frequently started pounding and she could not get her breath (Tr. 103). Examination revealed her blood pressure was 150/100 and regular (Tr. 104). There was no evidence of any particular heart disease. She showed voluntary splinting of her back and her right arm when it was in motion, but when distracted she lost her splinting both in the back and arm (Tr. 104). Dr. Pollack stated that the plaintiff, although she complained of innumerable pain and disabilities, walked quite freely out of his office without any disturbance in gait or any sign of the marked disability which she claimed. She was comfortable, joked and went up and down the stairs with only a difficulty when this was pointed out to her. Diagnosis: conversion reaction. The plaintiff was considered competent.

A subsequent report from Dr. Alinaghi Farrokh, internal medicine (Tr. 115), revealed that he again examined plaintiff on April 9, 1969 (Tr. 106). She had rejected his request to come to the office for a thorough physical examination and no laboratory data was therefore available (Tr. 107). Physical findings were non-specific (Tr. 107). Blood pressure was 160/80. There was no deformity of joint, muscle atrophy or neurological abnormalities to substantiate the plaintiff's subjective complaints. Diagnosis was osteoarthritis, degenerative and anxiety and neurosis.

Dr. John A. Pietropaoli, stated in June 1969 that plaintiff was last seen by him on June 30, 1969 (Tr. 112). Based on X-ray reports and the results of laboratory work which were or-

dered for the plaintiff the diagnoses were degenerative osteoarthritis, hypertension, and a history of fractures of both ankles, legs and wrists.

X-rays of plaintiff were taken on June 24, 1969, at the Genesee Hospital at the request of Dr. John A. Pietropaoli (Tr. 109). These showed the lumbosacral spine to have a rather marked list to the left. There were no degenerative changes and the sacroiliac joints were normal. The hands showed minimal changes at the proximal IP joints, "not sufficient to warrant a definite diagnosis of reheumatoid arthritis." There was an old deformity of the wrist bilaterally known as Madlungs deformity, in which specific bones were slowed in their original growth in the medial portion.

Dr. Lorie A. Gulino, radiology (Tr. 117), reported X-ray findings of plaintiff's cervical spine, chest, both knees, both wrists, pelvis and both hips (Tr. 110). The studies of the chest, knees and pelvis were negative. There were minimal degenerative changes of the cervical spine and moderate changes in the wrist, which produced the only indication of rheumatoid arthritis.

Plaintiff was examined on October 6, 1967 by Dr. Ralph W. Prince, at the request of the employer's insurance company (Tr. 120). She complained of her right shoulder, low back, both knees and the joints of her right hand. On physical examination she appeared to be a well developed, well nourished, tense, but pleasant and cooperative woman, appearing her stated age. The physical findings were essentially within normal limits. The proximal joints of the first, second and third fingers of the right hand were tender and slighly swollen with slightly increased warmth and a poor grip. There was also increased heat and swelling of the right shoulder with limitation and pain on elevation beyond 45 degrees and spasm in the lumbar musculature (Tr. 120-121). Dr. Prince felt that plaintiff was totally disabled at that time for her job as a plastic machine

operator due to arthritis (Tr. 121). He stated that it was difficult to classify this without further laboratory studies but it was probably a mixed type or low grade rheumatoid. He concluded that it was not possible at that time to predict her expected period of disability but it would probably be prolonged.

The medical evidence of record subsequent to remand is as follows:

In his reports dated March 23, 1970 (Tr. 135), and February 20, 1971 (Tr. 136), respectively, Dr. Pietropaoli stated that he had treated plaintiff since September 1968. He stated that she had severe osteoarthritis of the lumbar spine, wrist and hands; deformity of both wrist, "probably congenital", hypertension; and a history of fractures of both ankles, legs and wrists. In the first report (Tr. 135), he stated that in view of her constant pain in the affected joints at rest he would have to consider her totally disabled. In the second report (Tr. 136), he stated that she was completely disabled and needed every financial assistance in obtaining her drugs and medication (Tr. 136).

In his subsequent report dated December 9, 1972 (Tr. 129), Dr. Pietropaoli stated that the only confirmatory evidence of his diagnosis of osteoarthritis was the report of X-ray by Dr. Lorie A. Gulino. Dr. Gulino's report of the hand and wrist X-rays were compatible with moderately advanced rheumatoid arthritis, with loss of joint space and deformity of medial aspects of the radius, and soft tissue swelling over the ulnar side of both wrists. On this basis, Dr. Pietropaoli's diagnosis was: 1. mild degenerative arthritis-cervical spine, 2. moderate rheumatoid arthritis-wrists.

A report from Dr. Jared H. Krackov, internal medicine (Tr. 141), revealed that he examined plaintiff on September 17, 1972 (App. 40, Tr. 138). By history plaintiff had a syndrome (set of symptoms) of rather severe polyarthralgia since 1968 with a minimum of objective findings. Dr. Krackov stated that a

view of the supplied records revealed very little in the way of significant objective findings. Multiple X-rays had been taken in June 1969 and revealed normal sacroiliac joints and negative findings of her left knee and right knee. X-rays of her hands were not at all diagnostic of rheumatoid arthritis but possibly suggested a developmental deformity called Madlungs deformity, which was of doubtful clinical significance. Plaintiff also had a negative latex agglutination and normal uric acid in 1969. On physical examination she was 4' 11" in height and weighed 112 pounds (Tr. 139). She was somewhat dramatic in her presentation, groaning with most movements that were required for examination; however, when she left the office she was able to walk without any groans. Blood pressure was 160/100 and her pulse was 80. There was no limitation of neck motion. Funduscopic examination revealed definite arteriolar narrowing and AV nicking. There was questionable limitation of shoulder motion, no limitation of neck motion, no limitation of any other joint and no joint deformities, except for the right middle finger. That finger was swollen at the PIP joint and was kept in a flexed position. There was no swelling of any other digital joint and no Heberden's nodes. In addition no loss of muscle mass was noted. The sedimentation rate was 5 millimeters per hour which was normal. In conclusion Dr. Krackov stated that plaintiff had definite hypertension with grade 2 funduscopic changes and a deformity of the PIP joint of her right middle finger that was suggestive of trauma. There were no objective findings suggestive of rheumatoid or degenerative arthritis.

Dr. Frederick S. Erdman, Jr., radiology (Tr. 143), reported that based on X-rays taken on September 21, 1972, plaintiff's right shoulder and right knee exhibited no significant findings and no evidence of fracture (Tr. 142). His impression was of a "normal right shoulder" and "negative right knee."

The non-medical evidence of record is as follows:

As noted above, plaintiff did not have the requisite quarters of coverage to establish disability insured status in 1965 (Tr. 65). Her employment prior to that time had been fairly steady from 1961 through March of 1965 but had been preceded by a period of almost complete non-work from 1954 through 1960. Prior to 1965, plaintiff had worked as a salesgirl at Kresge's, a stock clerk at Grant's, a domestic in private institutions and private homes and a cook in a nunnery and for the SPCC (Society for the Prevention of Cruelty to Children) where she would be sent out to homes which needed domestic help. After 1965, plaintiff worked for a number of different companies, all of which appear to be industrial corporations (Tr. 119). The quarters of coverage gained from this employment established plaintiff's disability insured status.

Plaintiff's duties at Bourgeois, where she worked for a short time in 1966, are not stated in the transcript. She left there because of the low wages and the poor area in which the company was located (Tr. 39). Plaintiff's position with Hickok, which was seasonal in nature, consisted of putting buckles on belts and packing them. She worked for Hickok for less than a year, leaving in late 1966 because of the seasonal nature of the work and the offer of a steady job with Graflex (Tr. 31-32, 38-39). Plaintiff's position at Graflex consisted of assembling photographic equipment. She left this position in 1967 because the equipment was too heavy for her to lift. Plaintiff next worked for Nylomode for several months in 1967, her duties consisting of tending a plastic machine and cutting the plastic items as they came out (Tr. 25, 27-28). Plaintiff's husband has testified that he made plaintiff quit this position because of transportation problems (Tr. 39). She applied for and apparently received 26 weeks of disability benefits under an insurance policy with Travelers Insurance Company based on Dr. Prince's October 1967 examination (Tr. 42, 120). Plaintiff last

worked for a few days in July and August of 1968 as a companion to a 91 year old senile woman, but she quit this job because she found it too difficult (Tr. 25, 76-78).

Regarding daily activities plaintiff's husband testified at the October 1969 hearing that the plaintiff in "good warm weather could do her regular household duties, but if her legs bothered her she's done." (Tr. 41). He also stated that she could take care of her own needs, except that he helped her a little occasionally, and that she had trouble getting her arms over her head (Tr. 41-42). He was of the opinion that she would never work again.

Prior to the hearing, plaintiff had given a history of fractures of both ankles, legs, and wrists to Dr. Pietropeoli. At the hearing she alleged and exhibited an extreme difficulty in ambulation. This difficulty was described by the hearing examiner in his report as follows:

> "She walks across the room with a portion of her body from the hips up appearing to be swiveling beyond the control of her legs. She helps herself by extending an arm and resting it on the furniture as she passes."

Plaintiff testified that she had injured both legs previously and they are very fragile (Tr. 36). She further stated that she had been given crutches at one time subsequent to 1960, but had disregarded them in favor of ambulating by "grabbing on to furniture." (Tr. 35).

ARGUMENT

The decision of the secretary that plaintiff was not under a disability, as defined by the act, at any time when she met the insured status requirements of the act, is supported by substantial evidence and is therefore entitled to affirmance.

In order to establish entitlement to a period of disability and disability insurance benefits plaintiff has the burden of establishing that she was unable to engage in substantial gainful activity by reason of a physical or mental impairment, which can be expected to result in death or which has lasted or can be expected to last for a continuous period of at least 12 months and the existence of which is demonstrated by evidence supported by objective data obtained by medically acceptable clinical and laboratory techniques, at a time when she met the insured status requirements of the Act, Act §223(d); *Reyes-Robles* v. *Finch*, 409 F.2d 84 (1 Cir., 1969); *Henley* v. *Celebrezze*, 394 F.2d 507 (3 Cir., 1969); *Franklin* v. *Secretary of HEW*, 393 F.2d 640 (2 Cir., 1968); *DeJesus* v. *Finch*, 336 F. Supp. 1069 (D.C.P.R., 1971).

Evidence of an impairment which reached disabling severity after the expiration of plaintiff's insured status or exacerbation of an existing impairment after expiration has no relevance to the determination of entitlement to a period of disability and disability insurance benefits, even though the impairment itself may have existed before plaintiff's insured status expired. *Henry* v. *Gardner*, 381 F.2d 191 (6 Cir., 1967); *cert den.* 389 U.S. 993 (1967), rehearing den 389 U.S. 1060 (1968); *Seals* v. *Gardner*, 356 F.2d 508 (5 Cir., 1966).

Section 205(g) of the Act provides that "the findings of the Secretary as to any facts, if supported by substantial evidence, shall be conclusive." Accordingly, the Secretary's findings, if reasonable, should not be disturbed by the court on review. *Richardson* v. *Perales*, 402 U.S. 389 (1971), *NLRB* v. *Walton*

Manufacturing Co., 369 U.S. 404 (1962). It has been held that the conclusive effect of the substantial evidence rule applies not only with respect to the Secretary's findings as to basic evidentiary facts, but also to inferences and conclusions drawn therefrom. *Levine* v. *Gardner*, 360 F.2d 727 (2 Cir., 1966); *Rocker* v. *Celebrezze*, 358 F.2d 119 (2 Cir., 1966); *Palmer* v. *Celebrezze*, 334 F.2d 306 (3 Cir., 1964); *Celebrezze* v. *Bolas*, 316 F.2d 498 (8 Cir., 1963).

In the instant case, ten physicians and one hospital have submitted reports as to the state of plaintiff's physical and mental condition covering the period between 1965 and December of 1972. As might be expected from such a vast array of reports, there are certain conflicts in the medical findings contained therein as well as differences of opinion between certain physicians as to whether plaintiff is or is not disabled.

With respect to the foregoing, it is well established that "a physicians opinion regarding disability is not determinative since it deals with the ultimate issue which was for the Secretary to decide." *Torres* v. *Secretary of H.E.W.*, 333 F. Supp. 676 (D.P.R., 1971); citing *Martin* v. *Finch*, 415 F.2d 793 (5th Cir., 1969); *Jones* v. *Gardner*, 282 F. Supp. 56 (W.D. Ark., 1966). Rather, it is the function of the Secretary as trier of fact to examine all medical evidence of record and resolve any conflicts therein and his conclusion, if supported by substantial evidence, may not be disturbed by the reviewing court. *Richardson* v. *Perales*, 402 U.S. 389 (1971); *Moss* v. *Gardner*, 411 F.2d 1195 (4th Cir., 1969); *Vineyard* v. *Gardner*, 376 F.2d 1012 (8th Cir., 1967); *Bailey* v. *Gardner*, 368 F.2d 841 (6th Cir., 1956); *Celebrezze* v. *Bolas*, 316 F.2d 498 (8th Cir. 1965). The Secretary has performed this function and his conclusion is clearly supported by overwhelming medical, as well as non-medical, evidence of record.

The extensive report of Dr. Jared H. Krackov concerning his examination of plaintiff in September 1972, replete with a

plethora of clinical and laboratory diagnostic findings (X-ray, latex agglutination, uric acid, fundiscopic examination and sedimentation rate) indicated no objective findings suggestive of rheumatoid or degenerative arthritis (App. 40). Moreover, this physician found that plaintiff had no limitation of any neck or joint motion save for "questionable" limitation of shoulder motion and no joint deformities except for plaintiff's right middle finger. While Madlungs deformity was confirmed, it was noted to be of doubtful clinical significance. This aforementioned report tendered by a specialist in internal medicine clearly contradicts the unsupported assertions contained in the March 1970 and February 1971 reports of Dr. Pietropaoli that plaintiff had severe osteoarthritis of the lumbar spine, wrist and hands with constant pain in the affected joints at rest. Moreover, this physician contradicted his own previously mentioned assertions in his report of December 1972 when he stated that the only confirmatory evidence supportive of such assertions were the X-ray studies of Dr. Gulino and that based upon these studies his diagnoses were "mild degenerative arthritis — cervical spine" and "moderate rheumatoid arthritis — wrists."

As to the "complications" to her osteoarthritis alleged by plaintiff, it is apparent that they have no appreciable physical effect upon the severity of her impairment.

Plaintiff has alleged extreme ambulatory difficulties. The hearing examiner's finding that these ambulatory difficulties, as evidenced by plaintiff's peculiar gait at the hearing, were not subject to any medically determinable impairment was based on substantial evidence. While plaintiff gave a history of fractures to her legs, ankles and wrists at the hearing and in the recitation of her medical history to Dr. Pietropaoli, not only is there not any medical corroboration for these assertions, but the X-ray reports of two separate physicians in 1969 fail to show evidence of even a single fracture in any of these areas having even existed. (App. 38-39, Tr. 109-11). Furthermore, Dr. Pollack, in

the report of his examination of plaintiff in March of 1969 notes that, "she walked into the office fairly freely and displayed no difficulties in walking but later on, in the interview she gave many complaints of many types." Once again at the end of his report Dr. Pollack states, "This woman, although she complains of innumerable pains and disabilities, walks quite freely out of my office without any disturbance in gait or any sign of the marked disability which she claims. She is comfortable, jokes and goes up and down the stairs with only a difficulty when this is pointed out to her." Dr. Pollack's report also notes plaintiff's voluntary splinting of her back and right arm when they are in motion. Thus, there is not only an absence of evidence to support a medical basis for the symptoms displayed but also affirmative evidence that plaintiff has manifested restrictions which are self imposed.*

In appealing the decision of the hearing examiner, plaintiff alleged that her disability is caused by Madlung's disease. However, Madlung's disease, (deformity) by its very nature was present in the plaintiff from birth, and, therefore, in view of plaintiff's prior long and varied work history cannot be held to be disabling in and of itself.

There is recurring diagnosis of nervousness in the medical evidence of record. This nervousness has previously been described as anxiety, neurosis, hypertension and conversion hysteria. Of the many physicians of record who noted this nervousness, however, only Dr. McVeigh stated reservations as to its effect upon plaintiff's ability to engage in substantial gainful activity. These reservations of Dr. McVeigh as to plaintiff's emotional inability to adapt to new positions seem to

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*Dr. Krackov also noted during his examination of plaintiff that plaintiff was dramatic in her presentation, groaning with most required movements, yet left his office walking without any groans. Considering the observations of these two physicians, it is evident that plaintiff is not a very reliable informant concerning her physical condition. (App. 40).

have been conclusively dispelled by plaintiff's subsequent engagement in substantial gainful activity for five consecutive quarters. While at least superficially, the number of different positions that plaintiff held during these five quarters might seem to indicate an inability to engage in steady employment, it must be noted that plaintiff changed positions for personal reasons (i.e. seasonal nature of work, bad neighborhood, poor wages, heavy physical nature of work, etc.,) rather than an emotional inability to adapt. Indeed, in at least one instance (Hickok), plaintiff stated that she was very happy with her work but had to leave because it was seasonal (Tr. 32). Further, Dr. Prince, aside from Dr. Pietropaoli the only physician to find plaintiff's medical condition to be severe, did not even mention plaintiff's nervousness as a factor in his decision. Finally, Dr. Pollack's report contraindicates a finding that plaintiff's nervous condition impaired her medical condition to the extent that she would be unable to engage in substantial gainful activity. For while Dr. Pollack classed plaintiff's nervous condition as conversion hysteria, he not only found plaintiff competent but stated that she left his office without . . . "any sign of the marked disability which she claims." Surely if Dr. Pollack had found that plaintiff's nervous condition had any effect upon her medical condition, he would have so stated.

On the basis of a thorough consideration of the evidence of record, the Secretary concluded that plaintiff had not established that she suffered from any severely restricting impairment at any time on or subsequent to September 30, 1971, and therefore had not raised any question as to her ability to work as of that date in types of employment in which she had previously engaged, i.e., that she had not shown that she was disabled. As plaintiff did not establish an inability on or prior to September 30, 1971 to engage in occupations in which she had previously worked, the Secretary was not obligated to elicit vocational data bearing on the availability of alternative job

opportunities. *Laws* v. *Gardner*, 368 F.2d 640 (4 Cir., 1966); *Smith* v. *Gardner*, 361 F.2d 822 (6 Cir., 1966); *Dupkunis* v. *Celebrezze*, 323 F.2d 380, 382 (3 Cir., 1963).

CONCLUSION

It is respectfully submitted on the basis of all of the foregoing that the decision of the Secretary that plaintiff was not under a disability, as defined by the Act, at any time when she met the insured status requirements of such Act is supported by substantial evidence and is therefore entitled to affirmance.

Respectfully submitted,

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Johnson D. Hay, Publisher
Russell D. Hay, Board Chairman

The Daily Record

December 6, 1976

Re: WEIMER V RICHARDSON

State of New York)
County of Monroe) ss.:
City of Rochester)

Johnson D. Hay

Being duly sworn, deposes and says: That he is associated with The Daily Record Corporation of Rochester, New York, and is over twenty-one years of age

That at the request of

MR. GERALD J. HOULIHAN, ASST. UNITED STATES ATTORNEY

Attorney(s) for

Appellee

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of the above entitled case addressed to

MR. EDMUND CLYNES, ESQ.
616 Times Square Building
Rochester, NY 14614

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